TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Richard Palmer, M.D.

Respondent Name
United States Fire Insurance Company

MFDR Tracking Number
M4-16-3253-01

Carrier's Austin Representative
Box Number 53

MFDR Date Received
June 23, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "THE CURRENT RULES ALLOW REIMBURSEMENT"

Amount in Dispute: $540.47

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Division Note: The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged as received on June 30, 2016. 28 Texas Administrative Code §133.307(d)(1) requires that:

> The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information.

The insurance carrier did not submit a response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 19, 2016	Designated Doctor Examination (99456-W6-RE)	$500.00	$500.00
January 19, 2016	Muscle Testing (95831)	$40.47	$40.47

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.
3. 28 Texas Administrative Code §134.204 sets out the fee guidelines for division-specific services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 790 – This charge was reimbursed in accordance to the Texas Medical Fee Guideline.
   - D90 – Payment adjusted because the payer deems the information submitted does not support this level of service.
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.

Issues

1. Is the insurance carrier's reason for denial of payment supported?
2. What is the maximum allowable reimbursement (MAR) for the disputed services?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The dispute in question involves a designated doctor examination to determine the extent of the compensable injury, represented by procedure code 99456-W6-RE, and muscle testing, represented by procedure code 95831. The insurance carrier denied disputed services with claim adjustment reason code D90 – "PAYMENT ADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE."

   Review of the submitted information finds that the narrative includes findings related to the extent of the compensable injury and documentation of muscle strength testing. The insurance carrier's denial reason is not supported. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. Per 28 Texas Administrative Code §134.204(k),

   > The following shall apply to Return to Work (RTW) and/or Evaluation of Medical Care (EMC) Examinations. When conducting a Division or insurance carrier requested RTW/EMC examination, the examining doctor shall bill and be reimbursed using CPT Code 99456 with modifier 'RE.' In either instance of whether MMI/IR is performed or not, the reimbursement shall be $500 in accordance with subsection (i) of this section and shall include Division-required reports. Testing that is required shall be billed using the appropriate CPT codes and reimbursed in addition to the examination fee.

   The submitted documentation indicates that the Designated Doctor performed an examination to determine extent of the compensable injury. Therefore, the correct MAR for this examination is $500.00.

   28 Texas Administrative Code §134.203(c) states,

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
   > (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The Division conversion factor for 2016 is $56.82.

For procedure code 95831 on January 19, 2016, the relative value (RVU) for work of 0.28 multiplied by the geographic practice cost index (GPCI) for work of 1.000 is 0.280000. The practice expense (PE) RVU of 0.55 multiplied by the PE GPCI of 0.920 is 0.506000. The malpractice (MP) RVU of 0.03 multiplied by the MP GPCI of 0.822 is 0.024660. The sum of 0.810660 is multiplied by the Division conversion factor of $56.82 for a MAR of $46.06.

3. The total MAR for the disputed services is $546.06. The insurance carrier paid $0.00. The requestor is seeking $540.47. This is the amount recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $540.47.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $540.47, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Laurie Garnes	August 19, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.